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" Scire est nescire, nisi id me Scire alius sciret."

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SUPRARENAL HYPERTROPHY.

BY

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NOT many examples of suprarenal virilism treated successfully by operation are as yet on record. This particular one seems to deserve reporting, not only because of this, but also because of the unusual character of the lesion found. The following note is brief, but the illustrations which accompany it will, it is thought, make certain aspects of the disorder clearer than words could; particularly the cyanotic colour.

R. W., a female, aged 20, was sent to see me on 11th March, 1931, complaining of a growth of hair all over her body and face, with high blood-pressure. There was no history of any abnormality in the family. She had been perfectly well when young, and had no serious illness.

She first noticed that hair was growing excessively on her legs, arms and face in August, 1930, and that she was putting on weight very rapidly. About a month later she noticed a very considerable amount of hair growing on her body, especially the abdomen. Up to the time of admission it had been increasing in quantity, and was getting much more coarse. She developed so much hair on her face and upper lip that she was exceedingly worried by it, and used "Veet" to get rid of it. Her face got very much larger, and her colour became a deep purple, especially on the face, backs of arms, legs and back of neck. Her menstruation started when she was eleven years old, and she was quite regular until 1930, when from about January she had intervals of about two to four months, and before her visit she had had complete amenorrhœa for fourteen weeks. She had not complained of any aches or pains.

On examination, the hair that she described was very obvious. Her skin was very hard, dry and scaly, the papillæ being very prominent. The thighs showed a mottled red appearance. Below the knees both legs were a deep scarlet-purple, and the upper and posterior surfaces of both arms were of the same hue. There was also an area with a similar condition of purplish skin over the upper part of the back, extending from the sixth cervical to the fourth dorsal vertebræ. Nothing abnormal was found in the lungs, nervous system or urine, nor in the abdomen; no tumours were made out in the suprarenal areas. Her heart was rather rapid, and her systolic blood-pressure when first seen was 150, with a diastolic of 100. Her thyroid could not be felt. An X-ray of the skull showed no evidence of any pituitary lesion. Her blood sugar curve was normal, and Wassermann reaction negative. An X-ray of her kidneys after "Abrodil" showed nothing of importance, but there was a slight shadow on the left side. She was given thyroid gr. v. t.d.s. and a tablet of whole ovarian gland three times a day.

A diagnosis of suprarenal hypertrophy was made, and on 23rd April, 1931, an operation was performed by Mr. Walters, who found no evidence of any tumour. The kidney appeared

to be normal, the right suprarenal was not palpable, but the left was felt, and there were adhesions between it and the spleen. He removed the left suprarenal gland, which showed hypertrophy, the weight of it being five grammes (normal = 3–4 grammes). She made a very satisfactory recovery, and was discharged on 25th May, still on thyroid treatment.

Her periods then returned for the first time since December, 1930, and remained regular for the next four months. She was re-admitted to the Infirmary on 10th September, 1931. At that time, in her own words, she said, "I was very much better. My colour was much less the deep purple, and was a brighter red. The texture of the hair was much finer." She was kept on thyroid gr. v. twice a day, and also given intramuscular injections daily of 1 c.c. solution of anterior lobe of the pituitary, and also 1 c.c. ovarian extract.

As the hair on her face was causing her very considerable mental distress, she had an exposure to X-rays. The hair began to fall out in ten days, and in three weeks her face was quite clear, and much softer in texture. The hair on her arms and abdomen was treated with hydrogen peroxide, and became very much less visible. She was discharged again on 15th December, very greatly improved. Her periods ceased for a short time when she was in the Infirmary, but returned on going home, and she has been quite regular since. She continued to attend as an out-patient, and treatment with thyroid and ovarian extract was continued. Early in April this year she had a second application of X-rays to her face.

A very large number of observations have been made on her blood-pressure, which was not found on subsequent investigations to be as high as when she was first seen, typical readings in November and December, 1931, being 126 up to 134, but her weight has gradually increased, and on 5th April, 1932, she weighed 10 st. 2 lb. Her face is still large, and her cheeks still somewhat purplish-red in colour, but the disfiguring coloration has considerably diminished. Her complexion now is that of a red peach. The coarse hair has

entirely disappeared from her face, a light-coloured, soft, downy hair taking its place. The hair on the abdomen has not diminished; her back, however, is still red, her legs also are red, but much less so than when she was first seen, and her arms are practically normal. She is very much brighter and happier in disposition than when first seen.

SUPRARENAL VIRILISM.

BY

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THE case, notes of which follow, is deemed worthy of record because the tumour found post-mortem offered an adequate explanation of the symptoms observed during life. The patient was shown recently at a meeting of the Bristol Medico-Chirurgical Society by the writer of this note.

Until a year ago the patient, a girl aged 5 years, was to all appearances normal, mentally and physically. During the last twelve months she became fat, listless, unusually silent, and prone to sit about, disinclined to take an interest in her surroundings or to play with other children.

With the increasing fatness growth in stature was at an abnormally vigorous rate, hair developing on the limbs and body generally. There was no menstruation.

Some few days before she was brought to my notice there had been attacks of shortness of breath which had caused alarm, and the indifference to her surroundings had become extreme.

When first seen by me she was ten pounds above the weight and six inches above the height of a girl of like age. She was very fat; her size was at once a striking feature. The fatness was most pronounced on the face, which was bloated and greasy, presenting a marked acne with comedones in all stages of maturity. There was a thick layer of fat over the abdomen (circumference 26 inches), clavicles and chest. She was prevailed upon with difficulty to stand, preferring to lie on her back in bed, speechless and motionless, quietly observing one's movements about the room. There was a

coarse, dark and fully-developed pubic hirsuties, of female distribution, and fine hairs were obvious all over the trunk, upper arms and thighs, those on the back being about half an inch long.

The tongue was coated and constipation was marked. The heart-rate was 130, the sounds weak, and the blood-pressure 135/80—distinctly high for one of her age.

The nipples and surrounding areolæ were rather pronounced; there was, nevertheless, no actual breast development. The labia majora were unusually large and the clitoris markedly hypertrophic.

Blood urea, urea concentration and blood sugar tests revealed no abnormality, and a radiogram of the pituitary fossa was unexceptionable. Apart from the appearances outlined above clinical examination of the abdomen was negative.

After the lapse of a month the lower edge of the liver and the tip of the spleen became just palpable; the edge of the former now descended yet farther, almost down to the umbilicus, but no irregularity in its contour was obvious, and jaundice did not supervene. A resistance was now palpable deep in the right loin. The superficial mammary and epigastric venous anastomoses became very prominent. A fortnight after this enlargement of the liver was first noted, she complained of acute pain over its anterior surface, which was tender on pressure, and a fortnight later she died.

While she was under my observation the tongue was consistently moist, but furred; there was obstinate constipation and a quick pulse (130–150), with the mental and physical apathy referred to above.

Note by Dr. A. L. TAYLOR.

Post-mortem a large tumour was found invading and largely destroying the left kidney, only the lower pole of which remained. Fig. 1 shows the tumour in longitudinal section. The growth was soft and lobulated and of a slaty colour, with large areas of necrosis and some hæmorrhage, but showing practically none of the lipoid characteristic of the normal adrenal cortex. Nevertheless, the absence of any recognizable adrenal gland on this side, together with the clinical features of the case, made it clear that the tumour

was of adrenal and not of renal origin. The growth had extensively invaded the renal pelvis and the renal vein, which is seen greatly distended on the left of the illustration. In spite of this, the only discovered site of secondary growth was the liver, which contained several large round masses of soft hæmorrhagic appearance. The right suprarenal and right kidney were quite normal.

Microscopically the tumour has lost all resemblance to adrenal tissue, and consists of irregular strands and masses of atypical cells of varying size and shape, and of intensely malignant aspect. Numerous malignant giant cells and multinucleate cells are

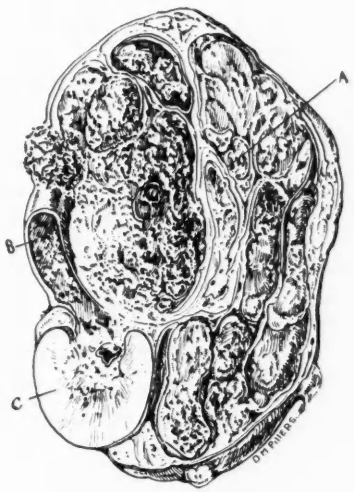

FIG. 1.

Malignant adrenal tumour with virilism.

Longitudinal section through the left adrenal and kidney, showing the extensive destruction of the latter by lobulated tumour-masses (A). The growth has invaded the left renal vein (B), which is greatly distended. The only recognizable kidney tissue is at the lower pole (C).

present and mitotic figures abound. Most of the tumour is necrotic. In the liver-secondaries the epithelial origin of the tumour is quite unrecognizable. The cells are of unequal size, but for the most part of rounded or polygonal shape, with very densely staining nuclei and relatively scanty cytoplasm. The cells are loosely arranged in an indefinite rather fibrillary stroma richly supplied with ill-formed blood-vessels. Here also extensive areas of necrosis and hæmorrhage are present. Both primary and secondary growths are almost entirely free from lipoid material.

THE MANAGEMENT OF THE EAR, NOSE AND THROAT IN INFLUENZA.*

BY

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INFLUENZA being as yet an undefined complaint, I should include under the above title any acute inflammation of the pharynx and upper air passages, particularly if occurring in epidemic form. Under the management of the ear, nose and throat in such cases I propose to discuss the measures which can be most usefully employed, both to shorten the duration, and to limit the extent, of the inflammatory lesion. The simplest plan seems to be to deal first with the general constitutional side of treatment. Under this heading I should attach the greatest importance to rest in bed, a dose of calomel, and aspirin and phenacetin internally. The preparation known as S.U.P.36 has been extensively used, with the idea of cutting short the course of the infection, but I myself, at present, should wish to postpone judgment as to its value. In some of the most acute cases, however, I am convinced that an injection of scarlatinal streptococcus antitoxin (globulins), if given early and in an adequate dose of (say) 20 c.c., will

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produce surprisingly good results. This applies particularly to cases associated with a hæmolytic streptococcal infection.

Secondly, as to the local treatment of the nose, throat and ear. It will, perhaps, clear the air if one first considers what might be done to an inflamed mucous membrane to assist resolution. In considering this, I believe it to be important to appreciate the fact that any discharge produced is the result of the inflammation and a proof of the resistance of the tissues to such inflammation. We are apt, I think, to regulate our treatment from the standpoint that it is the discharge itself that is the important factor in the disease. What can we do to an inflamed mucous membrane? We can leave it alone (and there is a good deal to be said for this); we can wash it; we can apply heat or cold, chemical antiseptics, or sera of supposed antitoxic or bactericidal properties. In dealing with a cavity with a narrow outlet we can also improve drainage by the use of vasoconstrictors, *i.e.* in the case of the nasal sinuses and middle ear, in which drainage and ventilation are of paramount importance. Dealing now with the various regions in turn:—

The Nose and Nasal Sinuses.—It is of importance here to teach the patient how to remove the discharge with the minimum risk of spreading the infection, particularly to the middle ear. Nose-blowing is an old-established custom, but owing to the necessity of observing social amenities it is usually performed badly. The safest method of clearing the nose is to sniff the discharge back into the nasopharynx and then to expectorate it, suction here replacing compression. If blowing is employed, only one nostril should be compressed at a time and no undue

force should be used. You must all have met with cases in which the patient has associated (I believe correctly) one particular forcible blow with the onset of an acute otitis.

As far as the washing of the nasal mucosa is concerned, I believe that this is better avoided. The application of antiseptics is of doubtful utility, but the use of 5 per cent. argyrol from a spray may possibly be helpful, and at any rate does no greater harm than to stain the handkerchiefs. The use of steam inhalations with eucalyptus and menthol does perhaps do something towards reducing the swelling of the mucous membrane, thus assisting drainage. Oily solutions of menthol, chloretone, cinnamon and carbolic, from an atomizer, are probably as good as anything.

Vasoconstrictors used in solution from a spray or applied on a small piece of cotton-wool are of very great assistance, particularly in cases in which the drainage from one particular sinus is defective, as shown by the presence of pain. Of the possible vasoconstrictors adrenalin is, I believe, better avoided, as tending to be followed by an intense reaction with vaso-dilatation. Cocaine is the most useful drug, but of course it must be used with caution. If given to the patient he should not know what it is, and if from a spray nothing stronger than a 1 per cent. solution should be used. If circumstances permit of it, the application of a swab dipped in a 5 per cent. solution by the surgeon is probably a better way. In my experience cocaine can safely be employed if care be taken to avoid its entry into the stomach. As an alternative to cocaine, ephedrine in oily solution is probably the best substitute.

In cases in which there are signs of defective

drainage from one or more of the sinuses, as evidenced by pain, tenderness and possibly fever, the application of heat externally by a hot bottle or fomentation is undoubtedly helpful. The adoption of a position which will tend to promote drainage from the sinus involved is also advisable, particularly after the application of a vasoconstrictor. The performance of a negative Valsalva by the patient, particularly, again, after the use of a vasoconstrictor, will sometimes uncork the obstructed orifice of a sinus. Finally, the occurrence of external swelling or the persistence of pain, tenderness and fever for more than a day or two may call for the intervention of surgery.

The Nasopharynx.—In many cases the complaint starts in the nasopharynx, but this region, being out of sight, tends to be out of mind. As far as local applications are concerned the region is difficult of access, and I think it is wise to be content with the use of an oily preparation from an atomizer through the nose.

The Pharynx.—It is curious that while acute inflammation in the nasal passages, as far as I know, never shows any involvement of the lymphatic glands, the exact converse obtains in the case of the pharynx. I think it probable that Nature here, as usual, has decided in favour of the specialist! She has handed over to the nose the function of warming, moistening and filtering the inspired air, while to the pharynx is given the duty of dealing with infections, by handing them on into the lymphatic circulation and thus calling up the general resistance of the body. The use of antiseptic washes in the case of the pharynx is not open to the same objections as obtain in the case of the nose. The mucous membrane here is a much more robust structure than the ciliated epithelium

of the nose, and, in addition, it is used to being bathed in liquids. The time-honoured method of gargling, when it can be carried out, is effective, and aspirin in suspension relieves the pain more than anything else. In the more acute cases a better proceeding is for the patient to syringe a jet of fluid into the back of the pharynx through the mouth with the head bent forwards. The fluid used should be hot and should contain bicarbonate of soda to dissolve the stringy mucus which is so distressing. It is customary to add some mild antiseptic, and I think that this is harmless. I myself am not in favour of the use of paints to the pharynx in acute inflammatory lesions, but if such are used they should be applied gently and be non-irritating. The customary Mandl's paint (a solution of iodine in glycerine) is, I am sure, frequently harmful. The associated swelling and tenderness of the cervical glands call for an external application, and from the patient's point of view I think there is nothing better than antiphlogistine.

The Larynx.—As this is the most overworked organ in the body (in most cases, at any rate), the great difficulty is to obtain rest to the inflamed parts. Bed, a taciturn attendant, and an exciting novel are helpful. In addition, if there is much cough, heroin is strongly indicated. As in the case of the nose, steam inhalations are customary and are possibly helpful.

The Ear.—Cases with middle-ear involvement form one of the most important classes with which we have to deal. The avoidance of forcible nose-blowing, nasal washes and other insults to the nose will often prevent the involvement of the middle ear. Should such occur, it is important to realize

that an acute middle-ear inflammation may proceed to any stage and then resolve. Although the stages merge into one another, one can recognize the following: hyperæmia of the lining of the middle ear; a serous exudate into the middle ear, or finally a purulent exudate into the middle ear. A similar state of affairs obtains in the mastoid antrum and cells, but the conditions in the mastoid cavities and the middle ear do not necessarily run a parallel course. It should be realized that the occurrence of an acute middle-ear inflammation is accompanied by swelling of the lining of the Eustachian tube, the obstruction so produced making the middle ear a closed cavity.

The variable course taken by cases of middle-ear inflammation renders their treatment very difficult, as the experience of one case is a fallacious guide to the next. Pain, fever and some defect in hearing are almost invariable indications of an acute otitis. As long as the membrane is intact it is not possible to introduce remedies into the middle ear, but it is customary in the early stages to drop something into the meatus. Opium and its preparations are frequently used as a local application, but so employed are, I believe, useless; on the other hand, the majority of cases of acute otitis have so much pain that they are the better for opium internally. Solutions of carbolic and glycerine are also frequently used, but the tendency is to use them much too strong, with resulting dermatitis of the meatus. I myself now depend on pure glycerine, but should carbolic be added it should not be in a greater strength than 5 per cent. Another fashionable drug, mercurochrome, is sometimes employed at this stage, but I know of no preparation which is more irritating to the surgeon. It can do no good through the intact membrane, but

by dyeing everything red it prevents any possibility of watching the progress of the disease! Heat to the side of the head is usually comforting and seems rational.

Finally, in many cases of acute otitis the question of surgery arises. When should a membrane be incised? There are two schools of thought in regard to this question: those who consider that every membrane which shows any signs of inflammation should be incised, and those who consider that this little operation should be reserved for cases in which there are definite indications. I belong to the latter group. The presence of a bulging membrane, with fever that has persisted for more than forty-eight hours, are, in my opinion, such indications. Apart from the question of incision, one must consider the still more difficult question of when a mastoid process should be opened and drained. Here again my outlook is somewhat conservative. With the exception of what may be described as fulminating cases, in which high fever, acute toxæmia and widespread mastoid tenderness are present from the onset of the complaint, I believe that it is better not to open and drain the mastoid process in the earliest stages of the inflammation. If one waits for a few days both local and general resistance to the infection are developed, and it will be found that the post-operative course of the illness is much less stormy than if one operates at a very early stage.

Finally, what should be the routine care of an acute middle-ear suppuration in which discharge is established whether by nature or by art? My practice is to continue the use of sterile glycerine drops for a few days, keeping the ear covered with a sterile dressing and preceding the putting in of the drops by a careful

wiping out of the meatus under as sterile conditions as possible. As soon as the temperature has fallen and the pain has ceased I believe in following as dry a line of treatment as is possible. The meatus should be mopped dry frequently, should be left uncovered at the earliest opportunity, and boracic or some other antiseptic powder should be insufflated to prevent decomposition of the discharge with resulting mixed infection.

NOTES ON THE TREATMENT OF SOME COMMON OCULAR AFFECTIONS.*

BY

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IN this short paper, which is rather disjointed, I want to bring to your notice a few facts connected with common ocular diseases.

Conjunctivitis.—If we consider the pain caused by this condition, we find it is always of a gritty or burning type, and very often the patient is convinced that he has a foreign body in his eye, as this may produce exactly similar symptoms. The character of the pain is of great importance from a differential diagnosis point of view, as it at once excludes such conditions as iritis and subacute glaucoma. The inflammation, or vascular injection, is also typical, the blood vessels being brick-red, tortuous, and moving with the conjunctiva because they are in it. They are largest at their origin, which is at the periphery of the eye, and gradually diminish in size as they near the corneal margin. There is always a discharge in conjunctivitis, but in mild cases this is not obvious: its presence can often be ascertained by everting the lower lid, and letting the sac fill with tears, when beads of discharge will be seen floating in the clear tears, or

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the patient may state that his lids are slightly stuck together when he wakes in the morning.

Now, as regards treatment, lotions and drops are all very well, but I am convinced that in order to cut an attack short there is no better treatment than painting the lids immediately the case is diagnosed, and it is the only efficient means for a case that has persisted in spite of treatment. One per cent. mercurochrome is as good as anything. Use a fine probe with a very little cotton wool, anæsthetise the eye with a drop of four per cent. cocaine, and in dealing with the upper lid do not evert it, but tell the patient to look down, catch hold of the lashes, and raise it from the eyeball, and then slip the probe under: by this method the painting is carried right to the top of the fornix, and so applied to the whole of the conjunctiva, whereas if the lid is everted and then painted the fornix is not touched.

Many cases of conjunctivitis will persist in spite of treatment, unless this includes nasal antiseptics. There need not necessarily be a history of nasal catarrh. The infection spreads to the eye via the nasal duct, and although antiseptics applied to the eye run down the duct into the nose, they are, apparently, not sufficient to deal with the infection.

Iritis.—The pain in this condition is very typical, and quite different from that of conjunctivitis. It is not in the eye itself, but in the bones of the orbit and face, and is of a neuralgic character. The vascular congestion is typical: it consists of straight, hair-like vessels of a lilac colour situated beneath the conjunctiva, and having their maximum intensity around the corneal margin. In iritis there is no discharge, but an increase in clear and normal tears. A considerable aid in the diagnosis of iritis is to compare

the irides of the two eyes: the affected one will show a contracted pupil, and change in its normal colour, and the marking on its surface will be obscured by œdema. The vision is always considerably reduced in iritis.

In investigating the cause of a primary iritis every endeavour should be made to exclude any septic focus. As a result of complete pathological investigation made over many years, we have found the teeth, accessory nasal sinuses, and prostate mainly responsible. As regards the teeth, there is no doubt that the apical abscess is the most responsible, and as it occurs in the well-cared-for mouth, and can only be recognized by an X-ray examination, it is often missed. The prostate should always be suspected with recurrent iritis in the young male, as we have conclusively proved that the gonococcus can lie dormant there for many years. Since complete pathological investigations are now made in cases of iritis, it is interesting to note that the so-called "rheumatic iritis" is far less common than in former years.

I will not trouble you with the treatment of iritis, which is well known, but there are one or two points worth emphasizing. For instance, sodium salicylate is by far the best drug to give internally, but it must be given in large doses. Heat, applied in some form or other to the eye, should never be omitted. The thin, small pad of cotton wool worn under a shade should be discarded, and a thick piece of gamgee tissue extending well beyond the orbit is the only means of keeping the eye well protected and at an even temperature.

Squint.—I will deal with the non-paralytic or concomitant variety. A squint occurring in a child

up to twelve months of age is of little importance unless it is considerable and fixed permanently in one eye. A child up to this age has acquired very little power of fixation, and in many cases, as this develops, the squint will disappear. After twelve months a squint should receive definite attention, as it is not likely to recover spontaneously, and will probably get worse.

To be able to undertake the treatment of squint intelligently it is necessary to realize that we are endeavouring (1) to prevent the squinting eye from becoming blind from disuse, and (2) so to educate and train the faculty of fusion that the child uses both eyes, fuses the two retinal images, and thus has binocular vision. Now, in order to prevent the squinting eye from becoming blind it must be brought into use, and this can only be done by excluding all or some of the vision from the straight eye. The most efficient way to carry this out is to exclude the straight eye altogether by strapping a pad over it. This is probably the best treatment if the child is not too young, and if it possesses useful vision in the squinting eye. It is, however, impossible to carry this out in young children, as they will not keep the pad on, and some method has to be adopted which they cannot remove from the eye. Atropine is most useful in these cases, as it paralyses the accommodation, and so, at any rate for near objects, puts the eye out of action. An instillation of a 1 per cent. solution once a week is usually sufficient. Whether atropine or some other method of occlusion is adopted, it will often be found that after prolonged treatment the original squinting eye becomes straight, and the squint appears in the other. This is an advantage, as it is definite evidence that the treatment

has achieved the required results, and that each eye has almost certainly good vision. In this way a squint may be made to alternate between the two eyes until the child is old enough for something more to be done. Never put atropine into both eyes at the same time.

As you know, squinting children practically always have some error of refraction, and it is of the greatest importance that this should be investigated. One is often asked at what age a child should be examined for and, if necessary, fitted with glasses. I would suggest that there is little harm in waiting until the age of two years, if in the meantime the atropine treatment is carried out. I know that some oculists attempt to make a child wear glasses whilst it is still in the cradle, but perhaps babies differ in different parts of the world.

Glasses having been prescribed, it is of the greatest importance that they should be worn constantly. Mothers often object to this, but the squint will not improve if the parents are allowed to have their way. Nor does the treatment of squint cease with the prescribing of glasses. The child may still be amblyopic in one eye, and the fusion faculty need training. In young children atropine may still have to be instilled into the straight eye, or in older children an occlusion disc worn over this eye to encourage the squinting eye to work. As the child becomes more intelligent every endeavour must be made to train the fusion faculty. This is best carried out by daily exercises with some form of stereoscope; five or ten minutes a day is quite sufficient for young children, and the child need not become bored with one set of pictures, as there are now so many different varieties made specially for this purpose of fusion

training. It is interesting to note that as the training of squinting children has been better understood, and so more adequately carried out, the numbers requiring operation have greatly diminished.

Foreign Bodies in the Eye.—These are most commonly found on the surface of the cornea and on the conjunctiva of the upper lid. If you find a foreign body in the cornea never fail to evert the upper lid, and look for one in this position also; it will often be found, and you will derive no credit for the removal of the obvious one if you leave the other. In removing a foreign body from the cornea use a sharp spud, and insert the point just under it and lift it out, your object being to remove as little of the epithelium as possible, as this is the chief barrier in preventing corneal infection. Blunt spuds must necessarily scrape off much of the epithelium. After the removal of a foreign body from the cornea some antiseptic should be inserted into the conjunctival sac, and this should preferably be an ointment, as its oily nature allays pain. We use an ointment of 1 per cent. mercurochrome or 1 per cent. iodoform. The eye, having been anæsthetized with cocaine, for the removal of the foreign body, remains insensitive to dust, etc., for some time; for this reason, and also in order to let the epithelium regenerate, a pad should always be worn over the eye for twenty-four hours.

Blepharitis.—This consists of an infection, usually staphylococcal in origin, and of the glands at the lid margin, and later of the hair follicles themselves. Although a very common ocular condition, it is one of the most neglected, yet it may often lead to much discomfort in after years. Those eyes which are very sensitive to such irritants as wind, dust, sun,

etc., often owe their trouble to a neglected blepharitis; also such conditions as ingrowing eyelashes, with consequent corneal irritation, can be ascribed to the same condition. Recurrent mild attacks of conjunctivitis will often rapidly disappear if the infection of the lid margin is dealt with.

The object aimed at in the treatment of blepharitis is to clear the infection, not from the surface of the lid margin, but from the glands and gland ducts. This can often be efficiently carried out by the so-called method of milking the lid glands. After cocainizing the conjunctiva, the edges of the lids are held with the thumb and forefinger, and squeezed with a movement towards their edges: the effect of this treatment is often surprising in a case which has withstood other methods of treatment, and it should be more generally adopted. In blepharitis one often finds that some antiseptic ointment has been prescribed, with instructions that it be smeared over the edges of the lids. This is often useless, as thick and hard scabs have formed, so that the ointment never reaches the lid margins. The scabs must therefore be first removed, and this must be done with great care, so that the underlying granulation tissue is not injured, as, if it is, fibrous thickening of the lid margins may result, with the formation of entropion or ectropion. The best way to remove these scabs, and this should always be done before any ointment is applied, is to soak the lid margins gently with a warm solution of sodium bicarbonate, which is applied with cotton wool swabs.

In the case of children with blepharitis never fail to exclude the presence of infected tonsils and adenoids; it is surprising how many cases will clear up after the nose and throat have been attended to.

Blepharitis rarely occurs in a healthy child, and every endeavour should be made to improve the general condition. General ultra-violet light baths are of definite value, and a change to country air is beneficial, but sea air often does these cases more harm than good, unless protecting glasses are worn.

Autogenous vaccine treatment is very valuable, and in severe cases the vaccine should be injected under the skin, close to the lid margin.

In conclusion, just a few words about atropine. Never use it indiscriminately, but only when you are certain of your diagnosis. Remember that it is the most powerful pupil dilator we possess, and its action cannot be counteracted by any other drug. if there is any doubt, use homatropine, which can be counteracted with eserine. Atropine is a severe irritant to the conjunctiva if used over long periods, and acute glaucoma induced by atropine is far from being unknown.

NOTES ON SURGICAL JAUNDICE.*

BY

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I HAVE no intention of attempting any exhaustive study of the subject of jaundice; I merely offer some remarks on the subject as seen solely from the surgical point of view. Thus I deliberately exclude from consideration all cases of jaundice due to any cause which may be roughly called medical, as well as any consideration of the pathological aspects, interesting though they are.

When a case of jaundice is seen by a surgeon, either in private consultation or on admission to a surgical ward, the cause is nearly always found to lie between three possibilities. These are: (*a*) obstruction of the common duct from within by a stone; (*b*) obstruction of the same duct, also from within but by some cause other than a stone, usually a primary growth of the ampulla; or (*c*) obstruction of the duct from without by the pressure of a pancreatic lesion, usually a carcinoma. A fourth form of obstruction affects the hepatic duct, most commonly by secondary growth in the portal fissure. In the differential diagnosis of these conditions careful attention to

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points in the history will often suggest the correct diagnosis.

In common duct obstruction by a stone there will be the usual long history of flatulent dyspepsia, distinct variation in the depth of the jaundice, often from day to day, together with considerable rises of temperature, often accompanied by rigors. There may have been attacks of colic in the past when the cystic duct was being negotiated by the stone, but severe pain when the stone is in the common duct is not usual. It is well known, of course, that a stone in the common duct does not necessarily cause even jaundice.

When the common duct is obstructed from without by a pancreatic carcinoma the history differs in several respects. The jaundice comes on without pain or discomfort, sometimes after a week or two's diarrhœa; it steadily deepens without sign of remission; temperature is normal or subnormal and no rigors occur. In jaundice of this type, in consequence of its being deeper and more prolonged, itching of the skin is more constant and more troublesome than in calculous obstruction. No deduction can be drawn from the presence of wasting; jaundice itself, without relation to the cause, leads to more rapid wasting than almost any other condition. Wasting, then, is not in itself any reason for suspecting a malignant cause for the jaundice.

In these two classes of common duct obstruction there are thus strong points in the history which will often enable a diagnosis to be made with reasonable confidence, and when one turns to the physical signs the correct diagnosis may be still more clear.

In the case of gallstone obstruction it is well known that the gall-bladder is hardly ever anything but shrunken, and beyond the enlarged liver physical examination reveals nothing.

In pancreatic obstruction one will find, in a large proportion of cases, palpable evidence that the gall-bladder is considerably enlarged; if it is, stone can be excluded with reasonable certainty. If it is not palpable in a case which otherwise suggests pancreatic obstruction, there may be two alternative explanations. One is that the gall-bladder is dilated, though not palpably so, because the liver is proportionately larger still, and conceals it; the other that the case is one of hepatic duct obstruction, in which case the gall-bladder is, of course, not dilated.

In differentiating so sharply between these various types of obstruction I do not pretend that the diagnosis is always so simple; in not a few cases there are points in the diagnosis that contradict one another in a most confusing way. If this is so, my experience is that when in serious doubt the cause is much more likely to be malignant than a stone.

I hope I have not devoted too much time to somewhat elementary points about the diagnosis, for it is to treatment that I want more particularly to refer.

Malignant obstruction of the hepatic duct permits of no treatment other than symptomatic. In the case of a stone in the common duct, wait for a remission of the jaundice, which will surely come, and remove the stone or stones, generally with the gall-bladder as well.

I want to deal in some detail with the treatment

of cases where the jaundice is due to a carcinoma of the head of the pancreas. When these patients are seen, especially in hospital practice, they have often a deep jaundice of six weeks' standing; they are advanced in years, considerably wasted, and often, at first sight, almost hopeless operative propositions.

The treatment, of course, can only be palliative; radical treatment of carcinoma of the pancreas is usually out of the question. The operation consists in short-circuiting the obstructed bile-duct by anastomosing the dilated gall-bladder to some part of the gastro-intestinal tract—the duodenum if possible, which is often not the case; failing that, the stomach, colon or jejunum in that order of preference. The anastomosis with the stomach is technically easy, physiologically not unsound, and in practice gives excellent results.

This brings me to a point which I would especially emphasize: it is extremely unwise to attempt to complete the anastomosis in a deeply-jaundiced patient in a single-stage operation. It is well known to everybody that the presence of jaundice, if deep, adds markedly to the mortality of any operation; in a case of stone in the common duct, one waits confidently for an early recession of the jaundice. In a pancreatic obstruction no such remission can be produced by any natural process, but the surgeon can, by a comparatively small operation, rid the patient of his jaundice; ten days after a cholecystostomy the jaundice will have disappeared, and at the end of that time the small wound can be reopened and the fundus of the gall-bladder anastomosed to the pyloric end of the stomach. The

disturbance is very small, and the general peritoneal cavity scarcely opened at all. It has been my experience that this operation is made much safer by so doing it in two stages.

It has been pointed out that the liver cells suffer severely from the effects of back-pressure when the common duct is obstructed, no less than do the renal cells in a comparable condition, *i.e.* in prostatic obstruction. No one would now do a single-stage operation for enlarged prostate at the end of six weeks' complete retention of urine.

In my opinion the case of common duct obstruction is strictly comparable. Although I have never, so far as I can remember, seen this point referred to in print, I make no claim to originality for it; in fact, I definitely disclaim it. I got the idea from Professor Burgess, of Manchester, in a paper he read at Bath some years ago. The idea struck me as essentially sound; since he gave me the idea I have never done a short-circuit in a deeply-jaundiced patient in one stage, and I shall never do it again.

One more point about these cases. They are, as I have said, in many cases and at first sight, almost hopeless operation risks, and some seem scarcely worth attempting. I believe that none should be refused the benefits of surgery without very careful consideration; if they are done in two stages it is surprising what apparently hopeless cases can be saved. If they can be rid of their jaundice the operation will be well worth while, especially if they have itching with it, as most have. It has been said that the mortality from suicide in the worst

itching cases is higher than the operative mortality; this may be an exaggerated statement, but it is not without a shadow of truth. At any rate, a patient who can be rid of his jaundice can expect many months of comparative comfort and a painless end, quite a different story from the final weeks of one with deep and increasing jaundice.

Before I close I should like to exemplify my remarks by a brief reference to three cases, about each of which there are points of interest.

The first was a lady, aged 61, but looking more. She had had deep jaundice for two months, and I diagnosed carcinoma of the pancreas and advised short-circuiting. This was refused until her husband, who was a doctor, had taken her on a medical tour of London, seeing in one day a well-known physician, an equally well-known surgeon, and visiting the Radium Institute. None of these authorities could offer any better suggestion than mine, and she returned to me.

I opened her abdomen, and found a thin, distended gall-bladder and a hard mass in the head of the pancreas. I drained her gall-bladder and she lost her jaundice, although she was rather slow in picking up. Three weeks later I completed the short-circuit, and she made a satisfactory recovery.

The after-history of this case is not without interest. After a short interval to convalesce the patient went for a seaside holiday, and the day before she went she rather staggered me by asking if I had any objection to her indulging in sea-bathing, which I sanctioned. When she returned she told me with great gusto that she had bathed every day except one, when it was too rough and stormy. She had, however, evened things up by bathing the following day before breakfast as well as at her usual time! She went on quite comfortably, looking after her house and doing her shopping on foot, for some months. I saw her for the last time just over a year from the operation, obviously failing fast, with a large abdominal tumour and some ascites, but no jaundice. She died a fortnight later.

The second case is that of a woman of 30—the youngest case of carcinoma of the pancreas I have ever seen. She had the usual signs and symptoms and I confirmed the diagnosis

by an operation, doing a two-stage anastomosis. She lost her jaundice and made a rapid recovery, so complete that, in view of her age, I naturally doubted the accuracy of my diagnosis. She returned to her work as a domestic servant, and I lost sight of her until many months later I saw her again, now very much wasted and with a large mass in her epigastrium. She died shortly after.

The third case was that of a woman of 46, on whom I operated in December, 1926. She had the usual history and physical signs and was deeply jaundiced. My note, taken at the time, states that she had a mass in her pancreas which was "evidently malignant." I did an anastomosis between her gall-bladder and stomach; she lost her jaundice and made a good recovery.

I heard of her several times in the following years, being told by her doctor that she was quite well, free from jaundice, but with an epigastric swelling of considerable size. I did not see her myself until January of the present year, when she appeared with no jaundice or epigastric swelling, looking quite well, but complaining of a swelling in her neck. This proved to be a single hard gland in the left posterior triangle, not indeed supraclavicular but rather in the upper part of the triangle. I excised this gland, expecting to find growth in it, but this was not the case. It was reported as being full of giant cells and presumably tuberculous.

I saw her again a few weeks later, this time with a swelling in the infraspinous region of her left scapula; the swelling had all the signs of a metastasis, and I thought it must be one. Again I excised it, and found a necrotic-looking mass, involving the muscle but not the bone. The pathological report said it was probably gummatous, an opinion that was confirmed by a strongly positive Wassermann reaction.

It is possible, or probable, that the original pancreatic lesion was of the same nature. If I find myself compelled to apologise for taking five and a quarter years to make the diagnosis, I feel equally entitled to congratulate myself on having saved her life by operating, for she would certainly have died of the biliary obstruction, and her death would have been certified as due to carcinoma of the pancreas.

To sum up my ideas on this question, I hold:—

1. That no case of obstructive jaundice should be refused operation without due consideration of the pros and cons.

2. That the operation in deeply-jaundiced patients should be a two-stage one.

3. That the relief obtained in successful cases is well worth the risk. Death, even at the surgeon's hands, is preferable to the only alternative—a few weeks of misery with death coming as a welcome deliverance.

4. That any case of jaundice which has lasted without remission for two weeks is potentially surgical. It is only by the realisation of this that we shall avoid unjustifiable delay and be able to give the maximum of relief to sufferers from this condition.

INSOMNIA.*

BY

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IF we are to arrive at any satisfactory conception of our subject, we must recognize the important fact that insomnia is a symptom and not a disease. Most people will, of course, readily admit of a reason for not sleeping, but it is only too common to hear people who ought to know better declaring that such and such an event is due to insomnia, and leaving it at that. I refer especially to suicide, which is so often attributed to insomnia, apparently to the satisfaction of coroners' juries and all others concerned. No doubt the symptom of insomnia may have accompanied the emotional state which led to suicide, and even intensified the trouble by the process of a vicious circle, so that it was the last straw which tipped the balance towards self-destruction; but it would be just as sensible to be satisfied with the statement that cough led to night sweats, and to neglect the underlying tuberculous infection which is responsible for both of these symptoms. A further danger of this conception is that both patient and doctor are all too apt to be satisfied if the symptom is treated and no attempt is made to go further. This leads to a widespread exhibition of hypnotic drugs, with

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or without the intervention of the medical man. I should be the last to deny the enormous value of such drugs, but they must be intelligently used.

It is often necessary for the success of ultimate treatment and desirable in the interests of humanity to remove such a distressing symptom as that of insomnia as soon and as rapidly as possible; but we should remember the lessons so insisted upon by our teachers, that the greatest circumspection should be used in the employment of analgesics for abdominal pain until a confident diagnosis has been made. So a corresponding therapeutic discretion must be used in the treatment of insomnia, and a diagnosis of the cause of this symptom must be insisted upon in order to lead to a cure of the disease of which this may be the most outstanding manifestation. To me it was a somewhat disquieting experience to hear more than one speaker at a recent discussion on suicide state that all that was necessary to prevent suicide was to treat the insomnia, and I confess I had a mental vision of the unfortunate patient eventually using the bottle of veronal tablets to cure him of his insomnia and his life at one and the same moment.

There can be no clear understanding of the nature of insomnia—the lack of sleep—unless we first understand the nature of sleep. To this extremely difficult question, "What is sleep?" I believe we have at last been given an answer by Pawlow and his assistants, which is at least pragmatically useful. During twenty-five years of increasingly exact experiments on the conditioned reflexes of dogs it was often found that the experiments were vitiated by drowsiness of the animals, which frequently passed into a deep sleep. This is not the place to enter

into the story of the conditioned reflexes, but certain experimental conclusions arrived at by Pawlow must be stated in order to understand this phenomenon. These are :—

1. The conditioned reflex is a cortical reaction.

2. Unlike the reflexes of the spinal cord and brain stem, these cortical reflexes are quickly susceptible to fatigue.

3. A conditioned reflex which is frequently repeated becomes "inhibited."

4. This "inhibition" or cessation of response is a symptom of fatigue, and is functionally useful in protecting the delicate cortical nerve cells from serious damage.

5. If an area is inhibited in this way the inhibition tends to spread to adjacent areas of the cortex, unless a fresh stimulus stops this advance of the inhibition. Thus, suppose an inhibition to be spreading from the occipital cortex from the fatigue of a visual reflex, this may be checked by the excitation of the temporal cortex by an auditory stimulus.

6. If unchecked, the inhibition may spread until it involves the whole cortex and even certain of the lower centres. Such widespread internal inhibition is sleep.

7. It was found that sleep intervened in the case of experimental animals under two conditions : (*a*) When a monotonous stimulus was repeated without the intervention of any extraneous stimulus. Here there was an unchecked spread of inhibition which we may compare with the drowsiness and sleep induced by any monotonous occupation, such as that of listening to scientific papers, or the effect of such measures as the counting of sheep going through a gate. (*b*) When a multitude of simultaneous stimuli were

all referred to the cortex in the form of conditioned reflexes. This results in a general fatigue sufficient to induce such a widespread cortical inhibition as to constitute sleep. We may compare this to the sudden deep sleep which follows extreme fatigue, or—better still—to the phenomenon often seen in children and puppies of sudden deep sleep suddenly supervening on wild and vigorous play.

This conception of the nature of sleep explains quite a number of problems which are otherwise somewhat baffling. If sleep is an internal inhibition as a result of the fatigue of afferent impulses reaching the cortex, and if such impulses are continually impinging on the cortex, then the inhibition will from time to time be sufficiently widespread to constitute sleep, providing any stimulus is not of such intensity as to check the spread of such inhibition. Hence we find that in normal health sleep is periodic, and ensues without the subject being conscious of any excessive fatigue.

Since all afferent stimuli proceed by way of the thalamic region, disturbances to this part of the brain, such as occur in encephalitis lethargica, may well disturb the normal rhythm of sleep, either by increasing the inhibition, by blocking these afferent stimuli, or interrupting it by fresh stimuli, initiated from the inflamed area. So far, then, and only so far, may we speak of a sleep centre, for sleep involves the whole cortex, but the paths to that cortex may pass through a very restricted area, and thus a restricted lesion may affect a wide expanse of nervous tissue, just as the bombing of an important railway junction disorganized the transport to a long line of battle front.

It is clear that the extent of inhibition of the

cortex which constitutes sleep varies from time to time and from individual to individual. Some people sleep like a log, others lightly; some dream, some do not. A dream is due to the stimulus of a pattern which disturbs the general inhibition sufficiently to allow the subject to be aware of the dream, and yet not sufficiently to allow of awakening, though a continuance and further spread of this excitation may wake up the subject. The nature of the state of being awake is obscure, but seems to involve, amongst other things, a correct reference in time and space in respect of the ego and the environment. In the dream there is no correct reference in time and space. A dream, however, may involve such an extent of stimulation that organized motion in the form of somnambulism is possible without the patient being awake. It is obvious, therefore, that much has still to be learnt as to the exact functions of the cortex, and while we may be reasonably certain from Pawlow's work that sleep involves a quantitative rather than a qualitative inhibition, we are still ignorant of the limits of that quantity.

From this we may conclude that the question presented to us by a patient who does not sleep is this: What is preventing the normal spread of internal inhibition throughout the cortex? The answer is, some abnormal afferent stimulus starting some fresh area of excitation and so interrupting this spread of inhibition.

We may now consider the nature of the various stimuli which arouse fresh centres of excitation in the cortex. The first and perhaps the greatest enemy of sleep is pain. Recent work has suggested that pain is not really a specific sensation, but is due to massive and irregular discharges of afferent stimuli

from any sensory nerve ending. Pain is apparently perceived subcortically in the thalamus, the cortex being concerned with its localization and with discrimination as to its severity. The arrival of such stimuli at the thalamus, however, is apt to start impulses in all sorts of directions in the thalamo-cortical radiation, so that sleep is very easily disturbed. If pain is responsible for insomnia, it is our duty to remove the source of this pain, or (if this is not possible) to prevent the painful stimuli from reaching the thalamus. This may be done in a few cases by such measures as a division of the posterior spinal roots, but for this purpose we must rely for the most part on the analgesic drugs, especially the opium derivatives headed by morphia. Morphia is a drug which is very effective as a rule in blocking painful stimuli, and has some general depressing effect on the cortex in ordinary doses; but if insomnia is not due to the intervention of pain, morphia is not likely to be successful as a hypnotic, except in elderly patients, for whom the milder opium preparations prove excellent hypnotics. I mention this simply to point out that we must discriminate in the use of hypnotics, and so far as our knowledge extends use the appropriate remedy for the appropriate occasion.

Apart from pain, which as we have seen is not a specific but a general sensation, we may classify sensory stimuli into Sherrington's three groups.

(i.) *Enteroceptive sensations.*—These come from the various internal organs, and by far the most important of these for our purpose are the circulatory. Cardiac patients are notoriously bad sleepers; the asthenic vagotonic young girl with too low blood pressure and the hypertonic old man with too high blood pressure alike sleep badly. A stimulant may cause

the one to sleep and a depressant the other. Exercise to warm the patient up before bed may sometimes be useful, but again may be fatal to all chance of sleep; but if we keep our principles in mind, it should not be difficult to discriminate which line of treatment is suitable for which patient. Similarly, digestive disturbances, irritability of the bladder or sexual excitation, are all liable to interfere with sleep, and the treatment of this form of insomnia is essentially the correction of the visceral anomaly, hypnotics being of little use unless this is done. In this connection diet may be of some importance, as minor degrees of flatulence are often responsible for insomnia. I would suggest, however, that what is necessary is a study of the patient's personal idiosyncrasies rather than a stereotyped régime, and I cordially agree with Crichton Miller in pointing out that the traditional glass of hot milk before retiring may send the patient to sleep because it is hot and wet, but may easily wake him up again because many people cannot easily digest milk in the recumbent position, and the resultant butyric fermentation blows out their stomachs to the detriment of their slumbers.

(ii.) *Proprioceptive sensations.*—These are the afferent impulses from the muscles and joints and locomotor system generally, and normally serve to record our position in space and the movements which we make through space. These sensations are abnormal in conditions of abnormal muscular tone, and are specially liable to interfere with sleep in such conditions as paralysis agitans and post-encephalitic Parkinsonianism. In such cases the drug which seems to block these aberrant stimuli and at the same time produce a general sedative effect is hyoscine, and in my opinion this is the drug of choice

in this particular connection. It is similarly often useful in the exaggerated motor activity of mania.

(iii.) *Exteroceptive sensations.* — These are the sensory impulses which come to us from the environment, whether by way of sight, hearing, smell, taste or common sensation (touch, heat and cold). Sleep is thus difficult in a bright light, a noisy room or in a hard bed, whether the happy hunting-ground of livestock or not. The normal environment in which we seek sleep avoids these extraneous stimuli, but in special circumstances we may have to take special precautions to eliminate these, whether by the exhibition of drugs or by other means.

All the foregoing stimuli, which may set up areas of fresh activity in the cortex and so defeat the spread of inhibition which is sleep, come to the cortex from subcortical levels, but more important even than these are those which arrive by transcortical routes. These are the psychic stimuli, chiefly of an affective or emotional nature, which must always be looked for in the examination of a case of insomnia. These disturbances are by no means always obvious to the physician or even to the patient, and call for considerable acumen in their elucidation. These are of special importance from the point of view of medicinal therapy, for it is often found that drugs, except in "knock-out" doses, have little effect. Shakespeare with his usual perspicacity realized this, for Iago says of the jealous Othello:

> "Not poppy nor mandragora,
> Nor all the drowsy syrups of the world
> Shall ever medicine thee to that sweet sleep
> Which thou ow'dst yesterday."

This is specially the case with morphia, for morphia, except in very large doses, is not a good hypnotic,

while it is an excellent analgesic. If pain, therefore, is the sole obstacle to the spread of inhibition morphia is very good therapy for insomnia; but if the obstacle to sleep is mental conflict, then it has to be remembered that the first effect of morphia, and to a less degree of alcohol, is to produce an euphoria in which all conflict is abolished, and a peace which passes his understanding descends upon the fortunate or perhaps unfortunate patient. It is this euphoria which he comes to desire far more than relief from insomnia, and he would far rather remain awake with such peace of mind than sleep without it. It is in this way that habits are made.

In certain of the psychoses, and in some of the more severe types of psychoneuroses, there may be such activity of the cortex, and there may be such a vicious circle of over-fatigue with violent activity that it is absolutely essential that the patient should sleep before anything in the way of treatment can be attempted. Under these circumstances drugs which have a general sedative effect on the cortex, such as paraldehyde, bromides, chloral and the barbiturates (luminal, etc.) are useful. The latter are particularly useful if a mild but prolonged effect is desired, since they are slow in action, but their effect is less transient than other hypnotics.

True cases of exhaustion neuroses and psychoses, though often simulated by anxiety and depressive states, are not so uncommon as some would have us believe. In these, as in the compulsive states, the habit of sleep is lost and must be restored. To my mind, the best drug in these cases is medinal, but this brings up an important point in dealing with hypnotics. As everyone knows, the number of drugs annually produced by optimistic firms as at last the

perfect hypnotic are legion, and no doubt everyone has his favourite amongst them, some preferring a suffix or prefix to a Greek word and others to a Latin. The truth is that it does not matter very much which of them is used so long as the physician who prescribes them knows how to use them; and personally I think the successful therapist will be the doctor who can use one or two with discrimination, rather than he who knows the name of half a score.

Anxiety cases and hysterics must be treated very carefully if drugs are to be used. The anxiety-neurotic seeks relief from his conflict before he seeks sleep, and the danger has been referred to in connection with morphia. The hysteric seeks a place in the limelight; and if he, or more often she, can by the symptom of insomnia secure the attendance of the physician to prescribe one drug after another, each more expensive than the last, especially if husband or father is paying, then the symptom is not likely to be given up. The unconscious but none the less real tendency of such patients to develop an undesirable dependence is illustrated when massage is used to induce sleep. In its place this is an extremely valuable remedy for insomnia, since it relaxes tension, redistributes the circulation and provides a monotonous stimulus; but we must remember the rich woman who is indeed sent to sleep by her masseuse, but cannot stir from home without her, lest her affliction, as she is fond of calling it, might return. The advisability of removing a symptom by establishing this permanent parasitism must be carefully considered.

I have endeavoured in this paper to sketch out the field of this rather diffuse subject, and since its object is to open a discussion it does not attempt to fill in any details.

Reviews of Books

An Index of Prognosis and End-Results of Treatment. Editor: A. RENDLE SHORT, M.D., F.R.C.S. Fourth Edition. Pp. xi., 599. Bristol: John Wright and Sons Ltd. 1932. Price 42s.—It is now nine years since the last edition of this book appeared, and not only has every section been thoroughly revised, but so many advances have taken place in the interval that about half the volume is new; for example, the chapter on the outlook in various forms of insanity. The book is more than ever unique and invaluable, for it supplies the reader with a critical review and exact comparison of the chief methods of treatment and their results, not a mere collection of pious opinions. In fact, its aim is, as far as possible, to create an exact science by tabulating all reliable figures as to the duration, mortality and complications of each disease, the precise effects and the percentage of success given by each form of operation or treatment. In short, it would add to Sydenham's "picture of the disease" an engineer's pocket-book of formulæ and statistics. Of course, the possibility of this varies with the disease. Where surgery in recent years has been most successful these statistics are so good and extensive that accurate prognosis can be made easily, but in diseases where science has not yet found a cure or a palliative there is little to be gleaned. Some of the most interesting chapters are those where the claims of medical and surgical treatment are conflicting, such as those on exophthalmic goitre and gastric or duodenal ulcer. Here the wealth of statistics given on both sides is astonishing and the summing up of the end-results is clear and fairly impartial. The value of these sections is very great to every practitioner and not least to the insurance expert. The magnificent Index Series would be sadly incomplete without this crowning volume in its revised form summing up the results of the others.

The Science of Signs and Symptoms. By ROBERT J. S. MCDOWALL, D.SC., F.R.C.P. Pp. viii., 440. London: William Heinemann Ltd. 1931. Price 21s.—This book is based on the author's *Clinical Physiology* (1927), and is perhaps rather more clinical in scope than the earlier volume.

Its main purpose is to explain on a rational basis the commoner signs and symptoms met with in practice, and to remind the practitioner of relevant physiological facts and principles which may have been crowded out of his memory by other matters, and it should serve its purpose well. But we think it should also prove useful to medical students during their clinical years and to those reading for the higher qualifications in medicine. The book covers a wide field, dealing with a great variety of clinical manifestations and interpreting them in physiological terms, also indicating the physiological basis of treatment in many cases. Perhaps the best sections, as one might expect of the author, are those dealing with the cardiovascular and the respiratory systems; other good chapters are those on gastric ailments, body temperature and fever. As a short appendix to the chapter on feeding, R. D. Lawrence contributes an interesting account of the spontaneous daily food intake of three normal individuals of different types. One would like to see, amongst other things, mention of proteosuria, Kendall's name in connection with the isolation of thyroxine, and fuller treatment of the electrocardiogram, the third nerve nucleus and the Argyll-Robertson pupil. The grouping of subjects is peculiar in some instances; for example, equilibrium and the cerebrospinal fluid are placed together in the same chapter; hypersensitivity, allergy and menstruation in another. On the whole the style is pleasant, making for easy reading. There is a good deal of repetition which may be excused by the attempt to make each chapter independent, though this will not account for exact repetition of whole sentences in the same chapter. There are, unfortunately, a number of misprints, as well as careless mistakes of spelling; the etymologist will hardly approve of "leucopænia," "leucopœnia," "gastrocnæmius," "hæmianopia," and "sella tursica"; and there are many gross spelling errors in the names of chemical substances and in proper names. The printing is good, though the paper employed makes the volume very heavy for its size. The book can certainly be recommended as a very readable link between physiology and practical medicine.

The Heart and Spleen in Health and Disease. By G. A. STEPHENS, M.D. Pp. xi., 139. 6 Figures. London: H. K. Lewis and Co. Ltd. 1932. Price 7s. 6d.—"Hech mon," cried the proud father as the regiment marched by, "they're a' oot o' step but oor Jock!" The author, conscious that his views are unique, anticipates with much reason that

"the Detractor will cut and tear him most cruelly." In fact, one has to search far in this book for a page free from mis-statements positively ludicrous in their naive simplicity. Dr. Stephens maintains that the heart sounds are caused by splashing at the free surface of the pericardial fluid—no free surface, no sounds: the jugular pulse is produced by the heart jerking the wall of the vein; nourishment is conveyed to the tissues by the red corpuscles, and oxygen via the white: "Throughout the whole animal kingdom there is but one virus": disease is an alteration in the rate of the basal exudation (not further defined): cancer is due to lack of oxygen—remedy, drink oxygenated milk: sudden heart failure during anæsthesia should be treated by massage of the spleen! On the subject of intestinal autotoxis, the evils of vinegar, and the dietetic value of uncooked cabbage he is merely tedious: far otherwise when writing of personal and crowd magnetism, telepathy, and the survival of the "aura" after death. There are some startling misprints—or are they such? When one reads that death from one cause is "more chronic" than from another, can one be certain that "the synopses of the autonomic nerves" is not really printed as written? It is seldom indeed that we can approve nothing in a book except the paper and type.

Sanitary Law in Question and Answer. 3rd Edition. By CHARLES PORTER, M.D., B.Sc., M.R.C.P., and JAMES FENTON, M.D., D.P.H. Pp. xvi., 219. London: H. K. Lewis & Co. Ltd. 1932. Price 7s. 6d.—This book, now in its third edition, is intended for the medical student and others studying for examinations. The catechism form in which it is written has been found very useful by those who have to acquire a grasp of a difficult subject in a limited time. Sanitary law is found to be such a subject by the average medical student, health visitor, and sanitary inspector. The manual is divided into two parts: Part I deals with Public Health Acts, and Part II with allied acts. This division helps to simplify the subject, which is also covered fairly thoroughly. The book will also be found to be valuable by those who wish to revise the subject.

Criminal Abortion. By L. A. PARRY, M.D., B.S., F.R.C.S., Pp. viii., 203. London: John Bale, Sons and Danielsson Ltd. 1932. Price 10s. 6d.—Criminal abortion, whether through economic pressure, as well as the stigma attaching to illegitimacy, is considerably on the increase. We therefore

welcome this book of Dr. Parry's as filling a gap in the literature on this subject, and as an effort to make practitioners conversant not only with the methods, but with the medico-legal consequences as relating to them. Dr. Parry deals first with the various ways, both by drugs and instruments, for procuring abortion, illustrating them aptly by cases that have been tried in the Criminal Court from time to time. He then summarizes concisely the common and statute law governing this offence, and lastly outlines the steps the practitioner should take when confronted by a case of this sort. We can recommend this very readable volume to all practitioners, and especially to those engaged as police surgeons or as gynecological specialists.

Individual Sexual Problems. By F. G. CROOKSHANK, M.D., F.R.C.P. Pp. 150. London: Kegan Paul, Trench, Trubner & Co. Ltd. 1931. Price 2s. 6d.—This small book contains three lectures dealing with sex problems from the standpoint of the Adler school of psychology. The title is perhaps a little misleading to the general reader, owing to the use of the word "Individual," which is used with a particular meaning. Individual psychology implies specifically Adler's school of thought. The book is very well written and interest is sustained throughout. It will well repay the attention of both the medical profession and the intelligent layman. It is full of sound common sense on the upbringing of children, on the conduct of parents, and it contains a brief but very significant résumé of the genesis of neurosis. The fault lies essentially in the way problems of life are tackled rather than in the problems themselves. While Adler admits the importance of the sex factor, for him it is but one of three important factors which contribute towards the total personality. The author summarizes these three cardinal agencies as Society, Sex and Subsistence. The way the individual meets their joint claims is his "Life-style." Perfect adjustment in all the departments makes the well-balanced, healthy individual. Maladjustment, and this includes repression, makes for neurosis. The author brings out well the difference in the Freudian and Adlerian point of view. For Adler it is not the occurrence of a psychical trauma of a sexual kind which is responsible for the development of neurosis, but the way in which the situation is met that matters. How much responsibility for ill-health, unhappiness, and spoilt lives generally rests with parents, doctors, and

teachers is clearly brought out. For this reason alone the book deserves to be widely read. The author has succeeded in condensing a maximum of wisdom in a very small space.

Radium and Cancer. By H. S. SOUTTAR, C.B.E., M.D., M.CH., F.R.C.S. Pp. viii., 64. London: John Bale, Sons and Danielsson Ltd. 1932. Price 2s. 6d.—The first and the last chapters of this book are well written and easy to understand, but as the author tried to compress a textbook into a pocket monograph, the intervening chapters are neither so well written nor so helpful. It is rather a pity that the author did not confine his remarks solely to the Radon or seed technique, as with the extra space then at his command the book would have been infinitely better. As it is, other methods have been less stressed than seed technique, and the author gives some rather scrappy information. On the whole, this book could only be recommended to those who are already well versed in Radium therapy, and merely wish to brush up their knowledge and get in touch with modern methods.

Thomson and Miles' Manual of Surgery. Vols. 2 and 3. By ALEXANDER MILES, M.D., LL.D., F.R.C.S., and D. P. D. WILKIE, M.D., F.R.C.S. Eighth Edition. Pp. xvi., 685; xii., 578. Illustrated. London: Oxford University Press. Price 12s. 6d. each.—The new (eighth) edition of this well-known handbook has been edited by Mr. Miles and Mr. D. P. D. Wilkie, who have enlisted the help of many of the present teachers in the Edinburgh School of Surgery to revise chapters dealing with the regions in which they are especially interested. For many years these handy volumes have been popular with students, and they reflect the sound, careful teaching which has made Edinburgh renowned throughout the surgical world. Mr. Wilkie's own work on obstructive appendicitis and cholecystitis is included, and every chapter shows the imprint of thorough revision. The clinical illustrations and the reproductions of radiographs are extremely clear and well chosen. We can recommend these handbooks to the student and practitioner. To have mastered their contents is to have acquired an up-to-date knowledge of the science of surgery.

The Technique of the Non-Padded Plaster Cast. By FRITZ SCHNEK, M.D. Pp. viii., 139. 169 illustrations. Vienna: Wilhelm Maudrich. 1932. Price $5.—During the last few years great interest has been taken in the treatment of fractures by the method of Dr. Boehler of Vienna. Briefly,

this consists in reduction by means of powerful skeletal traction and the prevention of any recurrence of deformity by the immediate application of non-padded plaster casts. The fitting of such a splint demands the utmost attention to details of technique, or disaster will follow in the form of gangrene, pressure sores, or non-union. Too little attention has been paid to plaster work in most of our general hospitals in the past, so that a book such as Dr. Schnek's should prove of great value to house surgeons and students. It is a pity that the present work is not more concise. If it were compressed and rewritten in better style it would be much more readily assimilable. It has probably suffered badly in the translation, for it is full of German turns of speech, typographical and grammatical errors. The translator has coined a horrible word "to fixate" which appear over and over again on every page, and the irritation engendered by such mistakes distracts the attention from the valuable matter which the book contains.

Acute Otitis Media. Pocket Monograph. By W. M. MOLLISON, C.B.E., M.Ch., F.R.C.S. Pp. vii., 71. Illustrated. London: John Bale, Sons and Danielsson. 1932. Price 2s. 6d.—This little book contains an excellent account of the symptoms, pathology and treatment of acute otitis media and its complications. There is nothing new or startling, but the teaching is throughout clear, concise and modern. We doubt whether the practitioner who needs instruction in the elementary anatomy should be encouraged to perform paracentesis. The author does not allow the diagnostic value to skiagraphy that modern technique deserves, but we are glad to see that he emphasizes the advantages of the magnifying, illuminated otoscope for examination of the membrane. For those who appreciate the "Pocket Monograph," the scope of which is necessarily somewhat restricted, this is a practical and trustworthy guide.

The Discharging Ear. Pocket Monograph. By A. G. WELLS, B.S., M.B., J.P., Barrister-at-Law. Pp. x., 92. London: John Bale, Sons and Danielsson Ltd. 1932. Price 2s. 6d.—The title of this book implies a treatise on otorrhœa. Actually, the first quarter is devoted to the external meatus. The author considers the illuminated otoscope "unsuitable" (does he mean "new-fangled"?). The anatomy is described very briefly, not always accurately,

e.g., the nerve supply of the meatus. "Wounds" and "Foreign Bodies" are outside the scope of his title altogether. The second quarter of the book deals with acute otitis media, supplying an unecessary foil to Mr. Mollison's essay on the same subject: skip this section. Chronic suppurative otitis media is described at some length. The *only* method of treatment mentioned is ionization (12 pages), a procedure dreaded by children, employed only occasionally by most otologists, and the darling of the School Authority's heart. The author recommends the risky method of employing "main" current through the patient, and warns the *operator* against receiving shocks: there is one illustration, a rheostat! This book shows the stigma of mass medicine—treatment of "cases" not "patients."

The Hygiene of Marriage. By ISABEL E. HUTTON, M.D. Third Edition. Pp. xii., 140. London: William Heinemann Ltd. 1932. Price 5s. This, the third edition of Dr. Hutton's book, fully maintains the good repute of the previous editions. The book is up to date, dealing with the various methods of birth-control as well as the many problems which confront women, and to a certain extent men, before and after marriage. It is written plainly and sensibly, and does not in any way appeal to those in search of erotic literature. The book can be confidently recommended by a doctor to his patients.

Text-book of Gynæcology. By SIDNEY FORSDIKE, M.D., F.R.C.S., Pp. xii., 290. Illustrated. London: Wm. Heinemann Ltd. 1932. Price 15s.—This small volume gives but an outline of the subject of gynæcology and can hardly be classed as a text-book. It has, however, some excellent features, the subject-matter is very easily understood and well set out, the diagrams and illustrations are clear and it contains all the recent advances. It would make a good elementary text-book for students and an excellent small reference book for practitioners, to whom it should appeal.

The Cause of Cancer. By W. E. GYE, M.D., and W. J. PURDY, M.B. Pp. xiv., 515. London: Cassell and Company Ltd. Price 30s.—The bulk of this book is devoted to experiments on the transmission of avian sarcomata. The authors attack "the entrenched and almost universal views" of the origin of cancer, namely that a change occurs

in the nature of the cells, which thereafter multiply uncontrolled. Cancer is a quite sporadic disease with no demonstrable connection between one case and another: so too, they point out, are poliomyelitis and tetanus. Histological evidence of a "cause" or of conversion of normal into malignant cells are lacking, and all attempts to transmit mammalian neoplasms by means of a cell-free extract have failed: merely "negative evidence"! A virus theory supposes a distinct virus for every kind of neoplasm in every species of animal, since each growth "breeds true"; yet they do not blench. They claim to have established that in each avian sarcoma there is (1) a living virus, the essence of neoplasia, non-specific either for type of growth or host; (2) an aggressin, intensely specific, which determines the *type* of growth the virus will produce, and which contains an unaltered molecular group derived from the cell structure. But "as to how the virus enters the body cells when natural infection takes place we have no knowledge." The authors assume that what has been proved for avian sarcoma may be applied without reservation to mammalian tumours, a bridge over which their "old-fashioned" opponents may not readily follow them. While the experimental evidence they adduce can appeal only to those who have the technical knowledge to assess it, the discussion of theories of cancer will interest all readers.

Research Work on the Pneumococci. By A. COWAN GUTHRIE, M.B. Pp. ix., 60. Illustrated. London: Baillière, Tindall & Cox. 1932. Price 7s. 6d.—This little book of sixty pages contains the account of a series of investigations, extending over eleven years, undertaken by a medical practitioner in active practice. The experiments were devised to determine the reason why an immune serum is lethal to an homologous organism "in vivo" when the same micro-organism can grow and multiply on the immune serum "in vitro." The work is set forth in detail, and the results are considered in relation to the therapy of lobar pneumonia. The chief features are the isolation of pneumococcal enzymes and their bio-chemical reactions. Stress is laid upon the action of "hæmatoxin" on the blood. The author is to be congratulated upon his perseverance and ingenuity. The book, however, needs to be read critically. It has, perhaps, been presented in its present form with such an end in view.

A Guide to Anatomy.—Third Edition. By E. D. EWART. Pp. xii., 338. Illustrated. London: H. K. LEWIS & Co. Ltd. 1932. Price 12s. 6d.—This book makes no claim to being in any sense a systematic text-book for medical students, but is especially written for students of Medical Gymnastics, Massage and Medical Electricity. It contains an enormous amount of information, accurately put together and simply arranged. It contains so much that one cannot resist a feeling of sympathy with the embryo masseuse, who may well feel appalled to find what she is in for. Will she be any better a masseuse for having learned (and forgotten) the surface-marking of the pulmonary valve? However, if it is in the syllabus it must be learned, for it may be asked: so it must go into a book of this kind. The book is an excellent one for the purpose indicated, and the illustrations, though simple, are satisfactory and adequate: the same applies to the index. The exiguous and inaccurate paragraph on page 175, referring to the surface-marking of the pleura, should be corrected and amplified, or omitted altogether. On the whole, a book well suited to its purpose, which will no doubt be welcomed by those for whom it is written.

Editorial Notes

Resignations of Professors Hey Groves and Rayner.

At the end of this session the Chairs of Surgery and Obstetrics will be vacated by Professor Hey Groves and Professor Rayner respectively. Their retirement takes place under the University regulation which makes the limit of occupancy of the Chairs in clinical subjects coincide with resignation from the active staff of the constituent hospitals. Professors Groves and Rayner, having been elected to the Consulting Staff of the Bristol General Hospital, come under the operation of this regulation, and it is with great regret that the Medical School will part with two such valuable teachers, both of whom are Bristol alumni.

Professor Rayner received the whole of his medical education at the Bristol University College and the Bristol General Hospital. Having taken his F.R.C.S. England, he was appointed Assistant Physician Accoucheur at the Bristol General Hospital in 1897, being promoted to the full staff on Dr. Newnham's retirement in 1923. In 1926 he was elected to the University Chair of Obstetrics in succession to the late Professor Walter Swayne. To the practical value of his teaching many generations of students can testify, for he was an outstanding teacher at the Bristol General Hospital long before he was called to occupy the University Chair. He has had an even wider field of usefulness as a consulting obstetrician and gynæcologist. Bernard Shaw says in the preface

to one of his plays: "The man who can, does: the man who cannot, teaches." He overlooked the possible existence of men like Rayner who, because they can do, are made to teach.

Professor Hey Groves commenced his studies in Bristol, and then went to Bart's. In 1905 he won the Gold Medal in the London M.S., and obtained the F.R.C.S. He was appointed to the Bristol General Hospital staff in 1903 and to the Chair of Surgery in 1922. His achievements in surgery are known all the world over, and he has been signally honoured by the Royal College of Surgeons by being elected to the office of Vice-President.

It is a matter for congratulation that both these Professors should have retired from the routine and exacting work of the University and Hospital in full health and still youthful vigour. They will have additional time to devote to the calls of private consulting practice, and their ripe experience and skill will in future be no less, but even more, at the disposal of the public and the medical profession. This is one of the compensations which an exceptionally early retiring age at the Bristol Hospitals and University carries with it.

* * * * *

Branch Meeting of British Medical Association at Taunton.

THE newly-constituted "Bath, Bristol and Somerset" Branch of the British Medical Association held its first meeting at Taunton on 29th June, in the Taunton and Somerset Hospital. Mr. W. G. Mumford, the President, was in the Chair, supported by twenty-four members. The President in opening the meeting expressed his hope that the new associations of this

Branch would prove prosperous and fortunate. Mr. J. R. Nicholson-Lailey, F.R.C.S., surgeon to the hospital, read a paper on "The Surgical Treatment of Peptic Ulcers," which it is hoped to publish in this *Journal* in the near future. The animated discussion evoked by the paper leaves no doubt that the extension of the Branch to include the whole county of Somerset will add greatly to its activity and interest. The meeting opened at 3.30 p.m. and closed shortly after 5 o'clock, tea being then served in the hospital. The success of this meeting will certainly increase the popularity and influence of the British Medical Association in the area which the Branch covers.

* * * * *

British Pharmacopœia (1932).

THE following letter has been received from the Registrar of the General Medical Council:—

DEAR SIR,

The new issue of the *British Pharmacopœia* (1932) will be published on the 30th September, 1932. I am instructed, on behalf of the Council, to say that the Council wholly reserve their copyright in the new work; and that nothing in the nature of substantial extracts from it must be published without the Council's express sanction. A memorandum relating to this matter in detail can be supplied on application. At the same time, no objection will be taken to such reasonable reference to the facts and figures therein set forth as may be properly made for purposes of criticism, review, and summary, or of study and research, but no information of any kind derived from the new issue may be published in book form before the 30th September, 1932.

Advance copies of the text of the *British Pharmacopœia* (1932) will be accessible on the 4th July, 1932, at this Office, and at 12 Queen Street, Edinburgh, and 35 Dawson Street,

Dublin, for the inspection of the public, from 10.0 a.m. to 1.0 p.m., and from 2.0 p.m. to 4.0 p.m. daily, excluding Saturdays, in order to give to manufacturers, pharmacists and others interested an opportunity of ascertaining the changes that are about to be made in official requirements, and of making the necessary arrangements to meet them.

Every person who takes advantage of this opportunity will be expected to observe the conditions above indicated, and will be required to sign an undertaking to that effect.

Inquiries by letter or telephone as to details of the contents of the new *Pharmacopœia*, or the changes about to be made in official requirements by its issue, cannot be answered. The advance copies themselves must be consulted.

I shall be obliged if you will insert this letter in your next issue.

Yours faithfully,

NORMAN C. KING,
Registrar.

*** The Medical Council Act, 1862, provides that :—

"The exclusive right of publishing, printing and selling the said *Pharmacopœia* shall vest in the said General Council."

The Copyright Act, 1911, may also be cited in this connexion :—

"2. (1) Copyright in a work shall be deemed to be infringed by any person who, without the consent of the owner of the copyright, does anything the sole right to do which is by this Act conferred on the owner of the copyright : provided that the following acts shall not constitute an infringement of copyright :—

"(1) Any fair dealing with any work for the purposes of private study, research, criticism, review, or newspaper summary."

Meetings of Societies

Bristol Medico-Chirurgical Society

The seventh meeting of the session was held in the Physiological Lecture Theatre of the University, on Wednesday, 13th April, at 8.30 p.m. Present: Dr. J. R. CHARLES in the Chair and seventy members.

The minutes of the previous meeting were read and confirmed.

Dr. F. J. MAYES showed skiagrams and Dr. A. L. TAYLOR the following pathological specimens: (*a*) Carcinoma of the œsophagus; (*b*) Diverticulitis; (*c*) Vertebræ from a case of multiple myeloma.

Dr. A. L. TAYLOR gave a short description and explanation of his specimens.

Mr. JOHN WRIGHT read a paper on **"The Management of the Ear, Nose and Throat in Influenza,"** reported on page 123.

The PRESIDENT congratulated Mr. Wright on his paper and declared the subject open for discussion.

Mr. E. WATSON-WILLIAMS pointed out the variety of forms which influenza took, and instanced the recent epidemic, in which during the early months aural complications had been common, but more recently the nasal sinuses had been affected. He, in agreement with Mr. Wright, seldom operated in the acute phase. As a rule he avoided early paracentesis, but thought that in suppurative otitis media it minimized damage. He used magnesium sulphate in cases of otorrhœa and found it very valuable.

Mr. ANGELL JAMES congratulated Mr. Wright and agreed with his views on treatment. However, he thought well of mercurochrome in spirit in the place of powder. He mentioned a recent case he had seen in which the tympanum had been full of blood. The case terminated fatally with a fulminating meningitis, and he wondered if early myringotomy would have been of value.

Dr. D. A. ALEXANDER was glad to hear the specialists expressing their trust in Nature. He mentioned the loss of hair, smell and hearing which might occur in influenza.

Mr. G. R. SCARFF agreed with Mr. Wright. He did not like the use of watery antiseptics in the ear, and stressed the importance of the principle of osmosis. He found that hæmorrhagic bullæ often occurred in the external auditory meatus in fulminating cases.

Mr. OSMOND BODMAN never regretted early paracentesis. He combined glycerine and magnesium sulphate in the treatment of otorrhœa. He used inhalations of menthol, and preferred a douche can to a syringe in the treatment of tonsillitis. He suggested the use of anæsthetin as a gargle.

Dr. PARKER referred to the use of calomel and Mandl's paint.

The PRESIDENT stated that he had himself found great value and comfort from nasal douching during an acute sinusitis. He further suggested the use of chloroform as a gaseous antiseptic.

Mr. WRIGHT, in reply, affirmed his objection to douching the nose, and said he did not believe in gaseous antiseptics. He thought that the early deafness in influenza was a nerve defect. The prognosis in hæmorrhagic cases was always very bad.

Mr. E. R. CHAMBERS then read a paper on **"Some Common Ophthalmic Conditions,"** reported on page 131.

The PRESIDENT thanked Mr. Chambers for his paper and declared it open for discussion.

Mr. R. R. GARDEN mentioned the recent campaign against squint in Bristol, and stressed the importance of constant observations from an early age. He thought that any case in which there was frequent squint in one eye only twelve months needed treatment. The earliest at which he had prescribed glasses was fourteen months. He thought the occlusion disc useless, and agreed with pad and strapping.

Dr. H. ROGERS thought that true rheumatic iritis was still common, the cause being the streptococcus viridans.

Dr. C. A. H. GEE mentioned the common association of blepharitis with dandruff of the scalp.

Dr. A. T. F. ROWLEY said he found that parting the lids of a lusty infant was a very difficult work.

Mr. CHAMBERS, in reply, gave details of the method of holding a baby in order to treat its eyes.

The last meeting of the session was held in the Physiological Lecture Theatre of the University on Wednesday, 11th May, at 8.30 p.m.

Present, Dr. J. R. CHARLES in the Chair and fifty-two members.

The minutes of the previous meeting were read and confirmed.

Dr. G. B. BUSH showed skiagrams and Dr. FRASER pathological specimens.

Mr. A. W. ADAMS described a case of **Cerebello-pontine Tumour** and showed the brain from this case.

Dr. G. E. F. SUTTON read a paper on **"Hyperpiesia."** A discussion followed in which the PRESIDENT, Mr. CHAMBERS, Dr. FRANK BODMAN, Dr. PERRY, Dr. WILSON-SMITH, Dr. PARKER spoke and Dr. SUTTON replied.

Mr. C. A. MOORE then read a paper entitled **"Some Notes on Surgical Jaundice,"** reported on page 139.

The PRESIDENT, Mr. DUNCAN WOOD and Dr. WILSON-SMITH discussed the paper, and Mr. MOORE replied.

The Medical Library of the University of Bristol,

WITH WHICH IS INCORPORATED

The Library of the Bristol Medico-Chirurgical Society.

The following donations have been received since the publication of the list in March, 1932.

	June, 1932.
American Laryngological Association (1) ..	1 volume.
American Laryngological, Rhinological and Otological Soc. (2)	1 ,,
Groves, Professor E. W. Hey (3)	6 volumes.
Kruse, Fritz (4)	1 volume.
Smith, W. Alexander, M.A., M.B. (5)	,,
Walker, Cyril H., B.A., M.B., F.R.C.S. (6) ..	15 volumes.
Wilmer Institution (7)	1 volume.

Unbound periodicals have also been received from Professor E. W. Hey Groves and Dr. Carey F. Coombs.

THE ONE HUNDRED AND FORTIETH LIST OF BOOKS.

The figures in round brackets refer to the figures after the names of the donors. The books to which no such figures are attached have either been bought from the Library Fund or received through the *Journal*.

Allison, N., and Ghormley, R. K. *Diagnosis in Joint Disease* .. 1931
Bailey, Hamilton .. *Emergency Surgery* .. .. Vol. 2 1931
Bertwistle, A. P. .. *Atlas of Radiographs* .. .. 4th Ed. (3) 1932
Birth Control and Public Health 1932
Black, G. .. .. .. *Eyesight and How to Care for It* .. .. (6)
Christie, H. K. .. .. *Technique and Results of Grafting Skin* .. 1930
Coates, V., and Delicati, L. *Rheumatoid Arthritis* 1931
Cornioley, C. E. .. *L'Ostéosynthèse des os longs* .. .. .. (3) 1931
Crookshank, F. G. .. *Individual Sexual Problems* 1931
De Vilhena, H. .. *A expressão fisica da Cólera* .. .. 2nd Ed. 1931
Ewart, E. D. .. .. *A Guide to Anatomy* .. .. .. 3rd Ed. 1932
Fifield, L. R. .. .. *Minor Surgery* .. .. 2nd Ed. 1931
Forsdike, S. .. .. *Textbook of Gynæcology* 1932
Gant, F. J. .. .. *Guide to the Examinations of the Royal College of Surgeons of England* .. .. .. (6) 1881
Greene, C. L. G. .. *Medical Diagnosis for the Student and Practitioner* .. .. (5) [1917]
Guthrie, A. C. .. .. *Research Work on the Pneumococci and their Enzymes* 1932
Gye, W. E., and Purdy, W. J. *Cause of Cancer* .. .. [1931]
Haret, G., Dariaux, A., et Quénu, J. *Atlas de radiographie Osseuse 3 Tomes* .. .. (3) 1931
Hill, L. .. .. .. *Recent Advances in Physiology and Bio-Chemistry* .. .. (6) 1908
Hillier, W. T. .. .. *A Theory of the Formation of Animals* .. 1932
Howe, E. G. .. .. *Motives and Mechanisms of the Mind* .. 1931
Hutton, J. E. .. .. *The Hygiene of Marriage* .. 3rd Ed. 1932
Huxley, J. H. .. .. *Lessons in Elementary Physiology* .. (6) 1888
Isenthal, A. W., and Ward, A. S. *Practical Radiography* .. (6) 1898
Jackson, J. H. .. .. *Selected Writings of* .. .. Vol. 2 1932
Javal, E. .. .. .. *Blind Man's World* .. .. (6) 1904
Kirchner, M. .. .. *Operationslehre II* .. .. (3) 1932
Knapp, A. .. .. .. *Medical Ophthalmology* .. .. (6) 1918
Knies .. .. *Relations of Diseases of the Eye to General Diseases* .. .. (6) 1895
Kruse, Fritz .. .. *Die Lösung des Problems der echten Epilepsie* (4)
Lancet Commission on Nursing—Final Report 1932
Lawrence, R. D. .. *Diabetic Life* .. .. 6th Ed. 1931
Le Conte, J. .. .. *Sight* .. .. (6) 1881
Lohmann, (W.) .. *Disturbances of the Visual Functions* .. (6) 1913
Mollison, W. M. .. *Acute Otitis Media* 1932
Parry, L. A. .. .. *Criminal Abortion* 1932
Pharmacopœia of the London Hospital .. .. (6) 1882

Porter, C., and Fenton, J. *Sanitary Law in Question and Answer* 3rd Ed. 1932
Richardson, B. W. .. *Biological Experimentation* .. .. .. (6) 1896
Schnek, F. .. .. *Technique of the Non-padded Plaster Cast* .. 1932
Short, A. R. .. .. *Index of Prognosis* .. .. 4th Ed. 1932
Stephens, G. A. .. *Heart and Spleen in Health and Disease* .. 1932
Stubbs, S. G. B., and Bligh, E. W. *Sixty Centuries of Health and Physick* .. .. [ ]
Symes, J. O. .. .. *Short History of the Bristol General Hospital* 1932
Thompson, C. J. S. .. *Quacks of Old London* .. .. (6) 1928
Turnbull, A. .. .. *Treatment of Diseases of the Eye* .. (6) 1843
Usland, O. .. .. .. *Kirurgiske Pankreassykdommer* 1932
Wallace, O. .. .. *Wayfaring in a Splint* 1931

TRANSACTIONS, REPORTS, JOURNALS, ETC.

American Laryngological Association, Transactions 53rd Annual Meeting .. .. (1) 1931
American Laryngological, Rhinological and Otological Society, Transactions 37th Annual Meeting .. .. (2) 1931
Medical Annual 1932
Quarterly Cumulative Index Medicus. Vol. 10 (1931) 1932
Surgical Clinics of North America. Vol. 12, No. 2 1932
Universities Year Book 1931
Wilmer Institution, Collected Reprints. Vol. II.. .. .. .. (7) 1932

Local Medical Notes

EXAMINATION RESULTS.

University of Bristol.—Students of the University have recently passed the following examinations :—

M.B., CH.B.—*First Examination. Pass :* Daphne V. Dennis, J. P. M. Forde, H. D. T. Gawn, F. J. W. Hooper, C. R. G. Howard, C. B. Jones, Jane Mackintosh, Margaret E. Morgan, G. L. Page, A. N. H. Peach, P. B. Ryan, R. J. K. Tallack, R. M. W. Travers, T. R. de V. Vallentin. *In Physics and Chemistry* (*Completing Requirements*) *:* Margaret H. Davies. *In Physics and Botany* (*Biology*) *Completing Requirements :* N. R. Matheson.

M.B., CH.B. (*Part I.*)—*Second Examination. Pass : In Organic Chemistry* (*Completing Examination*) *:* Margaret E. Morgan.

M.B., CH.B. (*Part I.*).—*Final Examination. Pass:* Margaret A. W. Hawkes (with distinction in Materia Medica, Pharmacy, Pharmacology and Therapeutics), A. V. House.

M.B., CH.B. (*Part II.*)—*Second Examination. Pass:* J. W. E. Snawdon.

M.B., CH.B. (*Part II.*).—*Final Examination. Pass:* (with First Class Honours), A. L. Eyre-Brook (with distinction in Surgery, Obstetrics and Pathology). *Pass:* (with Second Class Honours), O. E. L Sampson. *Pass:* K. P. Beaubrun, G. T. Bevir, R. G. C. G. Carlson, A. McD. Davies, H. F. M. Finzel, F. E. Fletcher, J. R. Gibbs (with Distinction in Forensic Medicine and Toxicology), Frances N. Salisbury.

M.D.—P. Phillips.

B.D.S.—*First Examination. Pass:* A. N. Brimelow, C. C. B. Plumley.

PRELIMINARY SCIENCE EXAMINATION FOR DENTAL STUDENTS (L.D.S.).—*Pass: In Chemistry (Completing Examination):* D. E. Royal. *In Chemistry and Physics only:* R. A. Hilton.

PRELIMINARY SCIENCE EXAMINATION FOR DENTAL STUDENTS.—*Pass: In Biology only (Completing Examination):* R. A. Hilton. *In Biology only:* J. F. Durie, H. D. Williams.

L.D.S. — *First Professional Examination. Pass: In Anatomy and Physiology (Completing Examination):* Frances M. Orton, L. E. Scull. *In Anatomy and Physiology only:* B. E. Ffrench, D. E. Royal. *In Dental Anatomy only:* L. K. A. S. Oxley. *Second Professional Examination. Pass:* J. Hewitt. *In Dental Materia Medica (Completing Examination):* J. H. G. Smith.

L.D.S. — *Second Professional Examination. Pass:* J. Hewitt. *In Dental Materia Medica (Completing Examination):* J. H. G. Smith.

L.D.S.—*Final Professional Examination. Pass:* Helena C. L. Blinkworth, W. V. Whiteford.

Conjoint Board. — M.R.C.S., L.R.C.P. — *In Chemistry:* A. L. T. Beddoe. *In Anatomy:* W. H. Hayes. *In Medicine:* Enid A. Taylour, A. M. Davies.* *In Medicine and Surgery:* O. E. L. Sampson,* A. L. Eyre-Brook,* H. F. M. Finzel,* Frances N. Salisbury,* F. E. Fletcher. *In Surgery:* G. T. Bevir, J. L. S. James. *In Midwifery:* Annie M. B. Walker, J. F. H. Eagles, E. O. Walker.

* Qualified.

L.D.S., R.C.S.—*First Professional Examination. Pass: In Dental Mechanics and Dental Metallurgy:* W. B. Lewis. *In Dental Metallurgy and Dental Anatomy and Physiology:* J. H. G. Morris. *In Dental Metallurgy:* W. White. *In Anatomy and Physiology:* L. Jonathan. *In Dental Anatomy and Physiology:* Beryl M. Davies, N. G. Harrison, D. Gent, J. D. Rees.

L.D.S., R.C.S.—*Final Examination. Part I.:* F. S. Bromley, J. S. Cochrane, R. H. Green, S. A. McCandlish, P. J. F. Shepherd, H. W. South, W. N. Trays.

Society of Apothecaries. — L.S.A. — *Pre-Medical and Primary Examinations. Pass (in Physiology only):* K. P. Pauli. *Final Examination. Pass (in Medicine only):* (Mrs.) Beryl Busby.

Bristol General Hospital.—The following appointments have been made :—Consulting Surgeon : E. W. Hey Groves, M.S., F.R.C.S. Consulting Physician Accoucheur : D. C. Rayner, F.R.C.S. Surgeon : D. G. C. Tasker, M.S., F.R.C.S. Physician Accoucheur : H. J. Drew Smythe, M.C., M.S., F.R.C.S., M.M. Assistant Surgeon : G. M. Fitz-Gibbon, M.D., F.R.C.S. Assistant Physician Accoucheur : F. J. Hector, M.D., F.R.C.S.

A British Medical Association Prize, awarded for the best essay, contributed by a student of the Faculty of Medicine in any one of the following Universities : Birmingham, Bristol, Durham, Leeds, Liverpool, Manchester, Sheffield and the Welsh National School of Medicine, on "The Importance of the Condition of the Teeth to the Medical Practitioner," has been gained by Mr. H. E. Pearse (Bristol).

Long Fox Memorial Lecture. — Mr. A. J. M. Wright, F.R.C.S., has been appointed Long Fox Lecturer for 1932.

Colston Medical Research Fellowship.—A Fellowship of £200 for the year ending 31st August, 1933, has been awarded to Dr. Bruce Perry for "An Investigation into the Ætiology of Coronary Occlusion."